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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

MARION M. WINSTEAD, ET AL.,

Petitioners,

v.

INDIANA INSURANCE COMPANY,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTION PRESENTED

May a state statute authorize motor vehicle insurance companies and their insureds to subordinate motor vehicle no-fault benefits to benefits provided by a self-funded employee benefit plan in violation of the plan's terms, ERISA preemption of state law and ERISA's grant of exclusive authority to the plan's trustees to manage and control the plan's assets?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioners Marion M. Winstead, Howard McDougall, R. V. Pulliam, Sr., Arthur H. Bunte, Jr., R. Jerry Cook, Robert C. Sansone, Loran W. Robbins and Robert J. Baker as the Trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund and the respondent Indiana Insurance Company.

None of the petitioners is a corporation.

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October Term, 1988

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v.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

The Petitioners pray that a writ of *certiorari* issue to review a judgment and opinion of the United States Court of Appeals for the Seventh Circuit, which was entered on August 22, 1988.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit is reported at 855 F.2d 430, and is reprinted in the Appendix, p. 1a, *infra*.

The memorandum opinion and order of the United States District Court for the Northern District of Illinois (Getzendanner, J.) is reprinted in the Appendix, p. 1b, *infra*.

JURISDICTION

The judgment of the United States Court of Appeals for the Seventh Circuit was entered on August 22, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTES INVOLVED

This case primarily involves Sections 514, 402, 403 and 404 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§1144, 1102, 1103 and 1104 (1982), and Section 500.3109a of the Michigan No-Fault Insurance Act, Mich. Comp. Law Ann. §500.3109a. Citation is also made to Section 3(1) of ERISA, 29 U.S.C. §1002(1), Sections 500.3101 and 500.3107 of the Michigan No-Fault Insurance Act, Mich. Comp. Law Ann. §§500.3101 and 500.3107, and Section 500.2236 of the Michigan Insurance Code of 1956, Mich. Comp. Law Ann. §500.2236. These statutory provisions are reprinted in the Appendix, p. 1d, *infra*.

STATEMENT OF THE CASE

The Petitioners are Trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund ("Trustees" and "Fund" respectively), which is an employee welfare benefit plan as described in Section 3(1) of ERISA, 29 U.S.C. §1002(1). The Fund self-funds all

medical, hospital and disability benefits that it provides to participants and beneficiaries who reside in thirty-three states. (R. 19: Plaintiffs' Additional Statement of Uncontested Facts at p. 1).

In the Fund's Plan Document ("Plan Document"), the Trustees establish rules of eligibility for receiving benefits, benefit levels, limitations on and exclusions from coverage and various terms and conditions applicable to benefits. As required by Section 404(a)(1)(D) of ERISA, 29 U.S.C. §1104(a)(1)(D), the Fund provides benefits to Fund participants and beneficiaries in accordance with the terms and conditions of the Plan Document.

Pursuant to their duty to utilize Fund assets prudently and to provide benefits on a uniform basis to all participants and beneficiaries, the Trustees have included a number of provisions in the Plan Document to avoid duplicate coverage and to ensure that the primary responsibility for providing benefits for specific risk injuries is not transferred from specific risk insurers, such as motor vehicle no-fault insurers, to the Fund. Thus, the Plan Document provides for coordination of benefits ("COB") with different types of coverages. The Fund's COB provision provides that where no-fault or personal injury protection ("PIP") motor vehicle insurance coverage exists, the no-fault or PIP coverage shall be primarily responsible for providing benefits to a mutually covered beneficiary who has sustained injuries as a result of a motor vehicle accident and the Fund shall provide excess coverage. (R. 19: Plaintiffs' Additional Statement of Uncontested Facts at pp. 1-2). Specifically, Subsection 1.42(f) of the Plan Document identifies some of the "Other Plans" with which the Fund coordinates benefits:

> Automobile, motorcycle or other motor vehicle insurance coverage authorized by law to provide benefits to or for a Covered Individual for bodily and psycho-

logical injury, including but not limited to, related hospital, surgical, dental and other medical expenses, which expenses are also covered by this Plan, and which insurance coverage was issued in conformity with "no-fault" type or "personal injury protection" type laws or other similar state or local laws or regulations.

Subsections 11.05(a), (b) and (c) of the Plan Document further provide:

(a) An Other Plan, as defined in Section 1.42(f), shall have primary responsibility for providing benefits. The above designation of an Other Plan as defined in Section 1.42(f), as primary shall prevail over any state or local law or regulation or provision in such Other Plan inconsistent therewith or contrary thereto.

(b) In the event an Other Plan, as defined in Section 1.42(f), fails or refuses to assume primary responsibility for the payment of benefits, then, in order that the Covered Individual will not be disadvantaged by such failure or refusal, this Plan may provide the Covered Individual with the benefits as provided by other provisions of this Plan. Payment of benefits under this subsection by this Plan shall be under a reservation of rights and shall be without prejudice to this Plan's right to recover the amount of any such payments from the Other Plan.

(c) Whenever payments have been made by this Plan pursuant to Section 11.05(b) which payments the Other Plan was required to make under Section 11.05(a) this Plan shall have the right to recover the amount of such payments from the Other Plan.

Thus, where a Fund beneficiary is injured in a motor vehicle accident and has no-fault coverage, the Fund will coordinate its benefits with benefits under the no-fault coverage and pay benefits on an excess basis.

In the State of Michigan, car owners are required to purchase motor vehicle no-fault insurance or deposit a security payment with the secretary of state, and motor vehicle insurance companies are required to offer motor vehicle no-fault insurance coverage and to pay medical benefits for injuries sustained in motor vehicle accidents. Mich. Comp. Law Ann. §§500.3101(1), 500.3107a. With certain exceptions not applicable to this case, the Commissioner of the Michigan Department of Insurance must approve all provisions of insurance policies, which are approved by virtue of their authorization by state statutes, insurance regulations or special application to the department of insurance. *See* Mich. Comp. Law Ann. §500.2236(1), (6). One provision mandated by the Michigan No-Fault Insurance Act is a COB provision which would transfer primary responsibility for providing benefits for injuries sustained in motor vehicle accidents from the motor vehicle no-fault insurer to other health and accident coverage possessed by the injured party. *See* Mich. Comp. Law Ann. §500.3109a. Section 500.3109a provides in pertinent part:

> An insurer providing personal protection [motor vehicle] insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

Id. In construing Section 500.3109a, the Michigan courts have held that where the motor vehicle no-fault insurer has issued a COB provision based upon Section 500.3109a and the other health and accident insurance coverage has a COB provision making no-fault insurance primarily re-

sponsible for the payment of benefits to a mutually insured party, the no-fault insurer's provision must be enforced, thus making the health and accident insurance coverage prime. *See Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986).

On August 31, 1985, Fund beneficiary Renee Crampton was injured in a motor vehicle accident which necessitated hospital and medical treatment. Respondent refused to assume primary responsibility for the payment of her medical benefits, claiming that the policy it issued contains a "coordinated benefits" clause making it excess coverage when there is group health and accident coverage. To prevent Mrs. Crampton from incurring penalties for failing to pay her medical bills, the Fund assumed primary responsibility for providing benefits pursuant to a reservation of rights. As of May 7, 1986, the Fund had provided $126,313.72 in benefits on behalf of Mrs. Crampton.

On May 14, 1986, the Trustees filed this lawsuit in the United States District Court for the Northern District of Illinois, Eastern Division, pursuant to 28 U.S.C. §1331, 28 U.S.C. §§2201-2202 and 29 U.S.C. §1132(e) as to the federal question regarding ERISA preemption of Section 500.3109a of the Michigan No-Fault Insurance Act. The Trustees requested declaratory relief providing that respondent is primarily liable for paying benefits on behalf of Mrs. Crampton and reimbursement of the benefits paid by the Fund and other costs.

Respondent admitted that its insurance policy was ". . . provided to Renee Crampton pursuant to Michigan's no-fault automobile insurance law." (R.18: Joint Stipulation of Uncontested Facts at p. 2). The coordination provision of respondent's policy, in pertinent part, provides:

These benefits are subject to the provisions of Chapter 31 of the Michigan Insurance Code. Benefits consist of the following:

* * * * *

14. For medical expenses for you or any family member:
    a. to the extent that similar benefits are paid or payable under any other insurance, service, benefit or reimbursement plan; and
    b. if Coordination of Benefits for medical expense is indicated in the Declarations by the words "Secondary Med" or "Secondary Med/Wage".
15. For work loss benefits for you or any family member:
    a. to the extent that similar benefits are paid or payable under any other insurance, service, benefit or reimbursement plan; and
    b. if Coordination of Benefits for work loss benefits is indicated in the Declarations by the words "Secondary Wage" or "Secondary Med/Wage".

The parties filed cross-motions for summary judgment, and after the issues had been fully briefed and oral argument had been heard, United States District Court Judge Susan Getzendanner granted respondent's motion for summary judgment and ordered the petitioners and respondent to prorate liability for providing benefits. (Appendix, p. 8b, *infra*.). After rejecting a series of decisions by several Michigan state and federal district courts upon this precise legal issue, Judge Getzendanner decided that the Michigan primary coverage rule is preempted by ERISA but that the coordination clause in the respondent's policy, which exists solely by virtue of this Michigan rule, is valid and enforceable. (*Id.* at pp. 4, 7). The district judge explained that, in the absence of Section 500.3109a of the

Michigan No-Fault Insurance Act, the respondent's insurance coordination clause is still enforceable because ERISA preempts state laws, not private contracts. (*Id.* at pp. 4-5).

The petitioners appealed, and the United States Court of Appeals for the Seventh Circuit affirmed the district court, holding essentially that Section 500.3109a is not preempted state action. *Winstead v. Indiana Ins. Co.*, 855 F.2d 430, 433 (7th Cir. 1988) (Appendix, p. 5a, *infra.*). The Seventh Circuit acknowledged that its analysis and resolution of the same legal issue differed from that of the United States Court of Appeals for the Sixth Circuit in the case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, ____ U.S. ____, 100 L.Ed.2d 216, 108 S.Ct. 1754 (1988). 855 F.2d at 434, 435. (Appendix, p. 8a, *infra.*).

THE REASONS FOR GRANTING THE WRIT

I.

REVIEW IS NECESSARY TO RESOLVE THE CONFLICT BETWEEN THE DECISIONS OF THIS COURT AND THAT OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT WHICH DECISION UNDERMINES ERISA PREEMPTION BY RULING THAT INDIRECT STATE ACTION IS NOT SUFFICIENT STATE ACTION TO REQUIRE APPLICATION OF ERISA PREEMPTION

The Seventh Circuit's decision in the instant case conflicts with the plain meaning and legislative history of Section 514 and other substantive provisions of ERISA and this Court's decisions concerning the breadth and applica-

tion of ERISA preemption. In this case, the Seventh Circuit avoided the issue of ERISA preemption of Section 500.3109a of the Michigan No-Fault Insurance Act by characterizing this state law as an attempt to "facilitate" the private choice of state residents. 855 F.2d at 433. (Appendix, p. 5a, *infra*.). Although the Seventh Circuit recognized that Section 500.3109a mandates the writing and selling of motor vehicle no-fault insurance policies which shift liability for paying benefits from no-fault insurers to self-funded employee benefit plans, the court concluded that this is not state action relating to such a plan, but only a "personal" choice made by an insured. *Id.* Preemption does not impair the "choice to avail oneself of such a policy," according to the Seventh Circuit, because this "choice" is not "compelled" by state law and is simply ". . . a private contractual matter between [the insured] and Indiana Insurance." *Id.* The Seventh Circuit has established a precedent that Section 500.3109a does not regulate, even indirectly, self-funded employee benefit plans and, for that reason, is outside the reach of ERISA preemption. Such a narrow reading of ERISA preemption conflicts with this Court's repeated rulings that even indirect regulation of self-funded employee benefit plans is preempted.

In several decisions, this Court has affirmed both the plain meaning and legislative history of Section 514 of ERISA by holding that ERISA's comprehensive preemption of state law was meant to minimize state interference with administration of employee benefit plans so that such plans would not have to be administered differently in each state in which they operate. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983); *Fort Halifax Packing Co., Inc. v. Coyne*, ____ U.S. ____, 96 L.Ed.2d 1, 107 S.Ct. 2211, 2217 (1987). Section 514(a) of ERISA provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. §1144(a). For ERISA preemption to apply, a state law must "relate to" an employee benefit plan. This Court has interpreted the phrase "relate to" in a broad, expansive manner, holding that a state law relates to such plan ". . . in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97. *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 95 L.Ed.2d 39, 107 S.Ct. 1549, 1553 (1987).

In reviewing the legislative history of Section 514, this Court has quoted from statements of ERISA sponsors that ERISA preemption is purposely broad in scope to protect ERISA-covered plans from a need to comply with conflicting and inconsistent state laws. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. at 1552; *Shaw v. Delta Air Lines*, 463 U.S. at 98-100. Indeed, Congress considered and rejected bills which allowed preemption of only subject matters expressly governed by ERISA and which did not include a deemer clause reserving regulation of ERISA plans to the federal government. 463 U.S. at 98. These bills were rejected not only because they would have required ERISA plans to comply with multiple and potentially conflicting state laws, but also because they raised the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. *Id.* at 99 n.20. Moreover, after a period of monitoring by the Congressional Pension Task Force and hearing by a

House Subcommittee, a report evaluating ERISA's preemption provisions was issued, and it stated: "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded." *Id.* at 100 n.20, *quoting*, H.R. Rep. No. 94-1785, p. 47 (1977).

This Court has repeatedly affirmed the broad preemptive scope of ERISA and prohibition against even indirect state action bearing on self-funded employee benefit plans. *See, e.g., Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 739, 747. In the *Metropolitan Life* case, this Court explained that it is merely enforcing Congress' mandate that self-funded employee benefit plans not be subjected to indirect state regulation:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

471 U.S. at 747 (footnote citation omitted). This Court has also rejected attempts to limit ERISA preemption to those laws which "specifically" regulate self-funded plans. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98.

The Seventh Circuit's characterization of the benefit-liability transfer in this case as a private contractual matter between the insured and a motor vehicle no-fault insurance company, not resulting from state action, is directly contradicted by the plain meaning and effect of Section 500.3109a of the Michigan No-Fault Insurance Act and the legislative history underlying this Michigan law. Section 500.3109a as interpreted by the Michigan courts requires

motor vehicle insurance companies to write no-fault insurance policies which shift most, if not all, of the risk of providing benefits for injuries sustained in motor vehicle accidents from motor vehicle insurance companies to "health and accident coverage." Mich. Comp. Law Ann. §500.3109a. In implementing the expressed state legislative purpose of reducing the cost of such insurance coverage and of eliminating duplicative recovery, the Michigan courts have interpreted Section 500.3109a to require that such coordinated motor vehicle insurance policies be sold for substantially reduced premiums, thereby making them attractive to Michigan residents. *See Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 424 Mich. 537, 383 N.W. 2d 590, 594 (1986). The plain meaning and effect of Section 500.3109a is that the state is regulating all types of health and accident coverages by requiring such coverages to assume primary responsibility for paying benefits for injuries incurred in motor vehicle accidents while converting motor vehicle no-fault insurance to excess coverage.

The legislative history underlying Section 500.3109a establishes that the Michigan legislature in enacting Section 500.3109a was exercising as much regulation of health and accident coverages as it was of motor vehicle insurance companies. In examining the legislative history of Section 500.3109a, the Michigan Supreme Court explained:

> The legislative history of §3109a suggests that the Legislature, in leaving the phrase "other health and accident coverage" unmodified by the word private, intended to give unrestrained application of §3109a to health and accident coverage from whatever source. The analysis of HB 5724 prepared by the House Insurance Committee indicates that the bill would eliminate duplicate coverage by making private accident and health insurance, as well as the group plans of Blue Cross and Blue Shield, primary sources of reim-

> bursement for accident-related medical and hospital expenses. Thus, both private and non-private plans were within the scope of the bill.

LeBlanc v. State Farm Mut. Auto. Ins. Co., 410 Mich. 173, 301 N.W.2d 775, 784 (1981) (footnote citation omitted).

The fact that Section 500.3109a delegates to Michigan insureds the right to elect between motor vehicle no-fault insurance with a coordination provision and one without does not extinguish the state action which creates that right. It is the state, not the insured, which mandates the issuance of these coordinated policies. All provisions in insurance policies, with certain exceptions not applicable to this case, must be approved by the Michigan Department of Insurance as being authorized by state statutes, insurance regulations or special application to the department of insurance. *See* Mich. Comp. Law Ann. §500.2236(1). Failure to file an insurance policy with and obtain the approval from the department of insurance renders that policy in violation of the insurance code, which requires the application of insurance code provisions where such policy provisions are less favorable to the insured than the code. *Bill v. Northwestern Nat'l Life Ins. Co.*, 143 Mich. App. 766, 373 N.W.2d 214, 217-218 (Mich. Ct. App. 1985), *appeal denied*, 425 Mich. 877, 389 N.W.2d 863 (1986). It is firmly established that the terms of insurance policies are strictly controlled and regulated by Michigan law, and insurance policies are distinct from private contracts in which parties negotiate the terms freely, at arm's length and without state action.

It is also fundamental that a state cannot delegate authority it does not possess. In restructuring the benefits that must be paid by motor vehicle no-fault insurers and health coverages to mutually insureds involved in motor vehicle accidents, the Michigan legislature delegated to

the insured the power to decide which coverage must provide benefits on a primary basis. As the Michigan Supreme Court recognized, Section 500.3109a was part of the ". . . legislative scheme vesting in insureds, rather than insurers, the option of coordinating benefits." *Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 383 N.W.2d at 596. Section 500.3109a unquestionably constitutes state action relating to an employee benefit plan.

The only authority cited by the Seventh Circuit in support of its conclusion that, in enacting Section 500.3109a, the Michigan legislature was only facilitating private choice of Michigan residents to purchase this coordinated insurance is *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756-58 (1985). 855 F.2d at 433. (Appendix, p. 5a, *infra.*). The Seventh Circuit relied not upon the ERISA preemption analysis in *Metropolitan Life*, but only upon this Court's analysis of federal preemption of state law under the National Labor Relations Act ("NLRA"), which, unlike ERISA, does not contain a statutory preemption provision. In rejecting the argument that NLRA preemption of a mandatory insured-benefit law, in favor of an insured employee benefit plan, was needed to prevent states from enacting minimum employment conditions that labor and management would otherwise be free to negotiate from their federally protected positions, this Court correctly noted that it cannot hold as preempted all local regulation that ". . . touches or concerns in any way the complex interrelationships between employees, employers and unions. . . ." 471 U.S. at 757.

The NLRA analogy relied upon by the Seventh Circuit is inapposite. Unlike the tenuous link between NLRA's protection of the collective bargaining process and state law mandating insured mental-health care benefits, Section 500.3109a directly impacts upon the Fund by authoriz-

ing motor vehicle no-fault insurers and their insureds to dictate when the Fund must pay benefits, and what amount of benefits it must pay, in contravention of the terms of the Fund's Plan Document. By delegating such control over Fund assets to motor vehicle no-fault insurance companies and their insureds, Michigan law usurps the Trustees' exclusive authority and responsibility under ERISA to control and manage plan assets in the best interest of all participants and beneficiaries. *See* 29 U.S.C. §1102(a)(1) (the plan must be administered pursuant to a written instrument and named plan fiduciaries have authority ". . . to control and manage the operation and administration of the plan."); 29 U.S.C. §1103(a) (". . . the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan . . ." except for certain circumstances not applicable to this case); 29 U.S.C. §1104(a)(1)(D) (plan fiduciaries are required to perform their duties solely in the interest of all participants and beneficiaries in accordance with the provisions of the plan document). The resulting shift of benefits liability to the Fund, from a no-fault policy issued in accordance with the mandate of Section 500.3109a, erodes the Trustees' exclusive authority to manage and control plan assets and reallocates contributions made to the Fund from Trustee-controlled benefits to a state-created subsidy of lower motor vehicle no-fault insurance premiums. Unlike the state law involved in the *Metropolitan Life* case, Section 500.3109a is not a remote regulation of the Fund outside the intended scope of ERISA preemption. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97 n.17. Instead, this state law works a severe and continuing impairment of the Fund's uninsured benefit structure, and the Seventh Circuit's reliance upon *Metropolitan Life* is misplaced.

In measuring the intended scope of ERISA preemption, the United States Court of Appeals for the Sixth Circuit held that Section 500.3109a does "relate to" self-funded employee benefit plans. *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89 (6th Cir. 1987), *cert. denied*, ____ U.S. ____, 108 S.Ct. 1754 (1988). Although the Sixth Circuit in *Northern Group* adopted an unprecedented states' rights philosophy in its creative interpretation of the Savings Clause of Section 514 of ERISA, it did so only after finding that Section 500.3109a conflicted "directly" with the terms of the self-funded employee benefit plan by requiring the plan to make insurance payments in violation of the plan's coordination provision. *Id.* The Sixth Circuit concluded: "Holding that this state law does not 'relate to' the plan would run contrary to the plain meaning of the text [of Section 514 of ERISA] and to the relevant case law and legislative history." *Id.*

Because of its failure to apply ERISA preemption to Section 500.3109a, the Seventh Circuit's decision in this case will result in substantial problems for the courts and for self-funded employee benefit plans and their participants and beneficiaries. The lower courts will be forced to resolve the serious conflict between this Court's and the Seventh Circuit's decisions. Self-funded employee benefit plans, including the Fund, will be faced with serious administrative and financial burdens. As this Court foretold in the *Fort Halifax* opinion, subjecting self-funded ERISA plans to differing state laws will disrupt their current uniform administrative systems. 107 S.Ct. at 2216. If this is to occur, the Fund may be compelled to ascertain and comply with insurance laws of thirty-three states possibly applicable to the Fund because of the Seventh Circuit's extremely narrow interpretation of ERISA preemption. Because the states have different and inconsis-

tent insurance laws, the Fund may need to expend considerable plan assets to achieve such compliance. Other financial burdens will also result. Subsidizing the motor vehicle premiums of Michigan beneficiaries was not an anticipated benefit cost of the Fund and, to do so, the Fund must suffer a substantial drain on its assets. The Fund will also be faced with additional litigation costs because the Seventh Circuit's decision creates uncertainty in the law as to when ERISA preemption applies, and thus it will undoubtedly encourage more litigation on the issue of ERISA preemption.

Since Section 500.3109a of the Michigan No-Fault Insurance Act does clearly relate to the Fund by requiring it to pay benefits in contravention of the Fund's Plan Document, it falls within the general preemption provision of Section 514(a) of ERISA. Although this state law regulates the business of insurance, bringing it within the scope of the Savings Clause of Section 514(b)(2)(A), it also regulates self-funded employee benefit plans such as the Fund. 29 U.S.C. §1144(b)(2)(A). Thus, the Deemer Clause must be applied, preventing a state from deeming an employee benefit plan to be an insurance company or engaged in the business of insurance. 29 U.S.C. §1144(b)(2)(B). Accordingly, Section 500.3109a must be preempted to the extent it regulates self-funded employee benefit plans, and coordination clauses in motor vehicle no-fault insurance policies must be invalid and unenforceable as to such plans, because these clauses adversely affect such plans and exist solely by the action of the Michigan legislature.

II.

REVIEW IS NECESSARY TO RESOLVE THE CONFLICT BETWEEN THE UNITED STATES COURTS OF APPEAL FOR THE SEVENTH AND SIXTH CIRCUITS ON THE QUESTION WHETHER ERISA PREEMPTS SECTION 500.3109a OF THE MICHIGAN NO-FAULT INSURANCE ACT

The United States Courts of Appeal for the Seventh and Sixth Circuits have issued decisions concerning Section 500.3109a of the Michigan No-Fault Insurance Act which conflict on the questions whether this statute is preempted by ERISA and in what manner responsibility for providing benefits should be divided between ERISA plans and motor vehicle no-fault insurers.[1] *See Winstead v. Indiana Ins. Co.*, 855 F.2d 430 (7th Cir. 1988) (Appendix, p. 1a, *infra.*); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987); *Hawkeye-Security Ins. Co. v. Teamsters Central States Health and Welfare Fund*, App. No. 87-1201, slip op. (6th Cir. June 21, 1988), *petition for cert. filed sub nom. Central States, Southeast and Southwest Areas Health and Welfare Fund v. Hawkeye-Security Ins. Co.*, 57 U.S.L.W. 3261 (U.S. Sept. 16, 1988) (No. 88-487) (Appendix, p. 1c, *infra.*). In

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[1] The decisions of the Seventh Circuit also conflict with decisions issued by the Courts of Appeal for the Third, Fifth and Ninth Circuits which followed this Court's analysis in *Metropolitan Life* in reaching their rulings. *See Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3rd Cir. 1987) (state mandated-benefit law cannot be enforced against a self-funded employee benefit plan due to ERISA preemption); *Childrens' Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985) (state mandated-benefit law cannot be enforced against a self-funded employee benefit plan due to ERISA preemption); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (state anti-subrogation law is preempted as to self-funded employee benefit plans).

considering the identical legal issues raised by the same self-funded employee benefit plan as the petitioner in the case at bar, the Fund, the Sixth Circuit held that Section 500.3109a clearly related to self-funded employee benefit plans and is within the scope of the general preemption clause of Section 514(a) of ERISA, but ruled that it was saved from preemption by application of the Sixth Circuit's balancing test.[2] 833 F.2d at 88-94. In addition, the Sixth Circuit rejected *pro rata* division of responsibility for providing benefits in light of the Michigan Supreme Court's decision in *Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 422 Mich. 537, 383 N.W.2d 590, 596 (1986), which held that under Section 500.3109a the health coverage provider has primary responsibility regardless of its coordination provision and the motor vehicle no-fault insurer has secondary responsibility. In contrast, the Seventh Circuit held that Section 500.3109a is not preempted by ERISA because it does not "relate to" an ERISA plan and that the ERISA plan and the motor vehicle no-fault insurers must share responsibility for providing benefits on a *pro rata* basis. (Appendix, pp. 4a-8a, *infra.*).

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[2] In the petition for writ of *certiorari* filed in the *Hawkeye* case and now pending before this Court, the Fund provides a concise explanation of why the Sixth Circuit's rulings in *Hawkeye* and *Northern Group* are erroneous. Among other reasons, the Fund maintains that the Sixth Circuit's interpretation of the Savings Clause of Section 514 of ERISA renders the Deemer Clause meaningless. The Fund also firmly believes that the Sixth Circuit's creation of a test requiring self-funded employee benefit plans to demonstrate a federal interest in national uniformity *independent of and beyond* the requirements of ERISA and requiring that this specific federal interest ". . . outweigh the McCarran-Ferguson interest in state regulation of insurance" directly conflicts with the plain meaning and legislative history of Section 514 of ERISA and this Court's decisions. Because the Fund's analysis of the Sixth Circuit's decisions is fully set forth in the *Hawkeye* petition, the Trustees do not repeat it in this petition.

The conflicts between the Seventh and Sixth Circuits' decisions create many serious problems. First, their conflicting analysis of ERISA preemption will no doubt create confusion among the lower courts within their circuits and possibly beyond in determining when ERISA preemption applies, and when it does not by reason of the Savings Clause exception. There is no logical way to reconcile the Seventh Circuit's holding that Section 500.3109a does not relate to ERISA plans with the Sixth Circuit's holdings to the contrary. Because all or most states have laws regulating coordination of benefits and other rules concerning the division of liability among duplicate or multiple insurance coverages, the issue in this case has a nationwide impact. Moreover, the Sixth Circuit's balancing test can easily be extended to other attempts at state regulation of ERISA plans through state insurance laws. Another serious problem is the invitation to forum-shopping, since the result will depend upon which circuit the plaintiff chooses. In the Sixth Circuit, primary responsibility for the payment of benefits will be imposed on the ERISA plan but, if that same plan files a declaratory judgment action in the Seventh Circuit, its benefit expense may be reduced to fifty percent.[3]

[3] In affirming the district court's ruling that liability for providing benefits should be divided on a *pro rata* basis, the Seventh Circuit relied upon Indiana Insurance's failure to file a cross-appeal on this issue and to raise arguments against proration before the district court. (Appendix, pp. 7a-8a, *infra.*). The Seventh Circuit also noted that proration was consistent with generally accepted principles from state common law and approved proration as "eminently fair and equitable." (Appendix, p. 6a, *infra.*). The Court warned, however, that ". . . it is by no means clear that we would follow *Northern Group Services* should the question be presented." (Appendix, p. 8a, *infra.*).

Still greater confusion will obtain if the litigation is brought in a Michigan state court. The Michigan Court of Appeals has construed ERISA preemption in a manner which directly conflicts with the analysis used and results reached by the Seventh and Sixth Circuits. *See State Farm Mut. Auto. Ins. Co. v. C. A. Muer Corp.*, 154 Mich. App. 330, 397 N.W.2d 299 (Mich. Ct. App. 1986). At issue in *C. A. Muer* was whether a self-funded ERISA employee benefit plan, with coordination provisions in its plan document making it excess coverage to certain other insurance coverage, could enforce its COB provision on the basis that Section 500.3109a is preempted by ERISA. In *C. A. Muer*, the Michigan Court of Appeals followed this Court's analysis in the *Metropolitan Life* case and held that ERISA preempted Section 500.3109a to the extent it regulated self-funded employee benefit plans and required that the plan's coordination provision imposing primary responsibility on the insurance company be enforced. 397 N.W.2d at 301-303.

The conflict between the Seventh and Sixth Circuits on the issues of application and scope of ERISA preemption threatens to spawn a multitude of lawsuits challenging the heretofore broad ERISA preemption recognized by this Court and to require an unnecessary diversion of limited judicial resources. As the law stands today, the lower courts are faced with choosing one of three conflicting interpretations of ERISA preemption and how it should be applied to the same state insurance law. This state of confusion can only deteriorate unless this Court issues a writ of *certiorari* in this case.

CONCLUSION

For the reasons discussed herein, this Court should grant this petition to resolve the conflict between this Court's interpretation of Section 514 of ERISA and that of the Seventh Circuit, to reconcile the conflict between the Seventh and Sixth Circuits, to prevent states from authorizing insurance companies and their insureds to set benefit levels and conditions in contravention of the terms of self-funded employee benefit plans and to forestall future adverse effects of such state statutes on such plans.

Respectfully submitted,

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Dated: November 18, 1988

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APPENDIX A

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 87-2437

MARION M. WINSTEAD, et al.,

Plaintiffs-Appellants,

v.

INDIANA INSURANCE COMPANY,
a foreign corporation,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 86 C 3414—**Susan Getzendanner**, *Judge.*

ARGUED MARCH 30, 1988—DECIDED AUGUST 22, 1988

Before CUDAHY, RIPPLE, and MANION, *Circuit Judges.*

CUDAHY, *Circuit Judge.* The plaintiffs-appellants are trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund (the "Fund"), a multi-employer, self-insuring trust fund governed by the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The defendant-appellee, Indiana Insurance, is an insurance company authorized to sell its policies in the State of Michigan. On August 31, 1985, Renee Crampton, insured by both the Fund and Indiana Insurance, was injured in an automobile

accident in Jackson County, Michigan. As a result, Crampton required medical treatment and hospitalization; the costs of these services were paid in good faith by the Fund. Subsequently, the Fund filed this lawsuit to have Indiana Insurance declared primarily liable for Crampton's coverage and to obtain reimbursement for those amounts already paid on Crampton's behalf. The parties cross-moved for summary judgment and the district court held that liability should be apportioned *pro rata*. We affirm.

I.

At the time of her accident, Crampton was insured by the Fund pursuant to a collective bargaining agreement covering her husband and funded by his employer. She was also covered by a no-fault auto insurance policy mandated by Michigan law and underwritten by Indiana Insurance. Both policies covered the medical expenses resulting from the accident and both contained a "coordination of benefits" provision providing that any "other" insurance plan covering the insured would be primarily liable for any medical or other health-related expenses she might incur.[1]

The Fund disclaims liability based upon the priority of coverage clause in its plan document. That provision reads, in pertinent part:

> Section 11.05 *PRIORITY OF COVERAGE WHERE COVERED INDIVIDUAL COVERED BY AN OTHER PLAN AS DEFINED IN SECTION 1.42(f)*
>
> (a) An Other Plan, as defined in Section 1.42(f), shall have primary responsibility for providing bene-

[1] Although Michigan law required Crampton to obtain no-fault coverage, she remained free to choose between a lower premium policy containing a "coordination of benefits" provision and a policy with slightly higher premiums without such a provision. *See infra* p. 5. The latter coverage is more expensive because it permits an insured to recover the entire amount of loss from the insurer, not just what is left unpaid by any other coverage considered "primary."

> fits. The above designation of an Other Plan as defined in Section 1.42(f) as primary shall prevail over any state or local law or regulation or provision in such Other Plan inconsistent therewith or contrary thereto.

In turn, Section 1.42(f) of the Fund plan defines an "Other Plan" to include any:

> Automobile, motorcycle or other motor vehicle insurance coverage authorized by law to provide benefits to or for a Covered Individual for bodily and psychological injury, including but not limited to, related hospital, surgical, dental and other medical expenses, which expenses are also covered by this Plan, and which insurance coverage was issued in conformity with "no-fault" type or "personal injury protection" type laws or other similar state or local laws or regulations.

On the basis of these provisions, the Fund moved for summary judgment, arguing that in the circumstances of this case federal ERISA law should be held to preempt state law. Accordingly, the Fund's "other insurance" clause would render it the insurer of last resort, thus limiting its liability to only those expenses left uncovered by Crampton's other insurance policies.

Indiana Insurance also moved for summary judgment, based upon the "other insurance" clause in its no-fault auto insurance contract. That provision states that under policies such as Crampton's (denominated "secondary med/wage") medical expenses are not covered "to the extent similar benefits are paid or payable under any other insurance, service, benefit or reimbursement plan . . . ." Indiana Insurance argued that, in the absence of controlling federal case law, when an "other insurance" clause of a non-ERISA automobile policy providing medical benefits conflicts with a similar clause in an ERISA insurance policy, federal courts should look to state law for the appropriate rule of decision. Predictably, Indiana Insurance asserted that in these circumstances Michigan law—the

law of the state where its policy was written and where the insured was domiciled—should govern. Moreover, the company cited a recent Michigan Supreme Court case, *Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986), which held that in the event "other insurance" provisions conflict, the health benefits insurer (here, the Fund) is to be deemed primarily liable to provide coverage.

The district court initially agreed with the Fund, holding that to the extent Michigan law would have the effect of imposing higher benefit levels than the Fund would otherwise provide, ERISA preempts Michigan law. The court went on, however, to reject as "unconvincing" the Fund's argument that, *a fortiori*, the contested provision of Crampton's insurance contract with Indiana Insurance was encompassed within the scope of ERISA preemption and thereby automatically rendered unenforceable. Instead, faced with two equally viable but conflicting "other insurance" clauses, the court declared them to be mutually repugnant and, guided by *federal* common law, held both insurers liable on a *pro rata* basis.

II.

On appeal, the Fund once again argues that federal ERISA law preempts the Indiana Insurance policy. To the extent that the latter's provisions conflict with the terms of the Fund's coverage, the terms and conditions of the Fund policy must be enforced. However, the district court rejected the Fund's broad construction of ERISA preemption, explaining that by its own terms ERISA was designed only to supersede "any and all *State laws* insofar as they may now or hereafter relate to any employee benefit plan." (Emphasis supplied). *See* 29 U.S.C. § 1144(a). *See also Fort Halifax Packing Co., Inc. v. Coyne*, 107 S. Ct. 2211, 2217 (1987) (although state laws mandating benefit payments "relate to" employee benefits *plans* and are thus preempted, the mere fact that a state law pertains to a type of employee *benefit* does not re-

quire that the law therefore must be preempted). We agree with the conclusion of the district court that the relevant provision of the Indiana Insurance policy is not rendered void merely as the result of Crampton's concurrent ERISA coverage.

The decision to purchase insurance coverage in addition to ERISA coverage featuring an "other insurance" clause is a decision which undoubtedly affects the Fund's potential liability for benefits payments and is, therefore, a decision that "relates to" an ERISA benefits plan. *Id.* Crampton's decision to so proceed, however, was a private contractual matter between her and Indiana Insurance; it was in no way compelled by state law. As the district court properly concluded, nothing in ERISA suggests that individuals are barred from acting as Crampton did in insuring themselves. In fact, a state's ability to facilitate such private choice has been held by the Supreme Court, albeit implicitly, *not* to be preempted by ERISA. *See Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 756-58 (1985). Michigan law requires nothing more of companies licensed to underwrite insurance within the state than that they *offer* reduced premium policies with coordination of benefits clauses to those insureds already covered by other health and accident coverage. Mich. Comp. Laws § 500.3109a. The choice to avail oneself of such a policy is strictly a personal one, and thus a matter that ERISA did not intend to preempt.

Having excluded the possibility that ERISA preemption causes the Fund's coordination of benefits provision to supersede the Indiana Insurance policy, the district court turned to federal common law to determine which insurer qualified as Crampton's primary coverage provider.[2] The court's analysis followed the approach taken

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[2] Although the district court relied upon what it termed "federal common law," the court was in reality fashioning federal common law from what has evolved generally in the states as the common law in similar circumstances.

by the Third Circuit in the only other case in which a federal court arguably reached the issue of apportioning liability between an ERISA policy and a non-ERISA policy containing incompatible "other insurance" provisions.[3] In *Northeast Dept. ILGWU v. Teamsters Local 229*, 764 F.2d 147 (3d Cir. 1985), the Third Circuit was presented with two different types of conflicting "other insurance" clauses, one of which the court held unenforceable as a matter of law. Thus, *Northeast Dept. ILGWU* never actually addressed the issue of how to choose between two truly conflicting and equally viable "other insurance" clauses. A footnote to the decision, however, indicates that "other courts faced with incompatible 'other insurance' clauses have frequently declared the clauses to be 'mutually repugnant' and have held both insurers primarily liable for the insured's loss on a pro-rata basis. *See* 8A Appleman, Insurance Law and Practice § 4910, at 477." *Northeast Dept. ILGWU*, 764 F.2d at 161 n.13. *See also* 16 *Couch on Insurance* §§ 62:79-62:81 (2d ed.). Application by the district court in this case of such a solomonic apportionment of liability is not only in keeping with generally accepted notions derived from state common law, *see* Appleman and Couch, *supra*, but seems eminently fair and equitable.

An additional issue remains to be resolved. In its brief on appeal, Indiana Insurance asks us to reverse that part of the district court's determination finding it liable for half of Crampton's benefits. As authority for its request, Indiana Insurance cites *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied* 108 S. Ct. 1754 (1988), which held that ERISA did not preempt Michigan's no-fault insurance scheme and

[3] While other federal courts have been presented with the general question whether and under what circumstances a coordination of benefits clause in an ERISA policy nullifies a similar clause in a non-ERISA policy, our research suggests that no court has actually decided how to apportion liability between two such policies when both their respective "other insurance" provisions are found to be viable and enforceable.

its attendant coordination of benefits component.[4] Fortunately, we need not parse the confusing and, at times, self-contradictory clauses of ERISA[5] nor engage in an analysis of the Sixth Circuit's decision in *Northern Group Services* because Indiana Insurance may not raise the preemption issue on appeal.

Indiana Insurance failed to file a cross-appeal here. While it is well-settled that an appellee need not file a cross-appeal in order to argue different grounds to support an affirmance, *see Washington v. Lane*, 840 F.2d 443, 445-46 (7th Cir. 1988), the filing of a cross-appeal *is* required where an appellee seeks alteration of a judgment

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[4] In *Northern Group Services*, the Sixth Circuit analyzed the Michigan no-fault law in terms of ERISA's preemption provisions and concluded that the federal statute did not preempt the state law. First, the court held that to the extent the Michigan statute required coordination of benefits clauses, it was preempted because such clauses "related to" ERISA benefits plans. *See* 29 U.S.C. § 1144(a). Next, the court found that because the Michigan statute could be construed to "regulate insurance" it was within ERISA's "savings clause," which provides (with an exception created by the "deemer clause") that preemption does not apply to state laws which merely "regulate" insurance. *See* 29 U.S.C. § 1144(b)(2)(A). Finally, the court found that ERISA's "deemer clause," providing that employee benefit plans are *not* to be "deemed" to be insurance companies for purposes of any state law purporting to regulate insurers or insurance, *see* 29 U.S.C. § 1144(b)(2)(B), did not operate to preempt Michigan's statute. The court held that the "deemer" clause could only override the "savings" clause if there were some ERISA-related interest in federal uniformity outweighing the interest articulated by Congress in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in favor of state regulation of insurance. Because the Sixth Circuit could discern no federal interest in a unified federal common law to govern conflicting "other insurance" clauses, *Northern Group Services* held that the "deemer" clause was inapplicable to the Michigan statute and thus the statute remained saved by the "savings" clause.

[5] The Supreme Court has observed that ERISA's preemption provisions "are not a model of legislative drafting." *Metropolitan Life Insurance Co.*, 471 U.S. at 739; *see also MacLean v. Ford Motor Co.*, 831 F.2d 723, 726 (7th Cir. 1987).

rendered in whole or in part in its favor. *Jordan v. Duff and Phelps, Inc.*, 815 F.2d 429, 439 (7th Cir. 1987). Consequently, Indiana Insurance is not entitled to relief in this court from that portion of the district court's judgment finding it partially liable for Crampton's benefits.

Similarly, whether or not the Sixth Circuit's preemption analysis in *Northern Group Services* is correct, Indiana Insurance has waived arguments derived from that analysis for purposes of this appeal by failing to advance them in the district court. *See e.g., Johnson v. Artim Transportation System, Inc.*, 826 F.2d 538, 547 (7th Cir. 1987). In the district court Indiana Insurance argued that state (Michigan) law ought to provide the rule of decision in this case *not* because ERISA did not preempt state law but because there was no applicable federal common law on which the court could rely. Indiana Insurance now contends that it felt constrained from contesting the preemption issue in the district court for fear that it might thereby incur Rule 11 sanctions; this seems a weak explanation. It is true that at the time the Fund brought this lawsuit federal case law (all of it from district courts) addressing ERISA preemption of non-ERISA "other insurance" clauses was apparently unanimously adverse to Indiana Insurance. But none of these cases, all from district courts outside the Seventh Circuit, could be said to control the decision of a district court in this case. And also, there were no decisions on point in the Seventh Circuit when this case was before the district court. It is most unlikely that a district court faced with an issue of first impression in its own circuit would impose Rule 11 sanctions on a party who, while recognizing adverse precedent elsewhere, nevertheless urged the court to find differently. Indiana Insurance's waiver of the preemption issue below thus ought not to be excused. In any event, it is by no means clear that we would follow *Northern Group Services* should the question be presented.

III.

In conclusion, we hold that the district court correctly found: (i) that ERISA does not preempt and thereby did not render unenforceable the "other insurance" provision contained in Renee Crampton's no-fault policy; (ii) that the Fund's and Indiana Insurance's coordination of benefits clauses should be declared mutually repugnant; and (iii) that the contested liability be apportioned *pro rata*.

AFFIRMED.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 86 C 3414

MARION M. WINSTEAD, et al.,

Plaintiffs,

v.

INDIANA INSURANCE COMPANY,

Defendant.

MEMORANDUM OPINION AND ORDER

SUSAN GETZENDANNER, District Judge:

On August 31, 1985, Renee Crampton was injured in an automobile accident in Jackson County, Michigan. As a result, she required medical and hospital treatment. This litigation seeks to resolve which of two insurance funds is responsible for covering the costs of that treatment. Both have moved for summary judgment.

Undisputed Facts

The plaintiffs are trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund ("Fund"), a multiemployer trust fund governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 USC § 1001 et seq. The fund has self-funded all medical and hospital benefits paid out since February, 1976. Nelson Aff. at ¶ 12. The defendant ("Indiana Insurance") is an insurance company authorized to sell its policies in the State of Michigan. At the time of the accident, Mrs.

Crampton was covered by the Fund because of her husband's employer-made contributions to it pursuant to a collective bargaining agreement. The Cramptons were also protected by a no-fault automobile insurance policy purchased from the defendant. The Fund, which has made payments covering Mrs. Crampton's medical expenses, seeks to have Indiana Insurance declared the primary coverage provider; it also seeks reimbursement from the defendant for those amounts already expended.

The plaintiffs base their position on the priority of coverage provision in the Fund's plan document. That section reads in pertinent part:

> Section 11.05 *PRIORITY OF COVERAGE WHERE COVERED INDIVIDUAL COVERED BY AN OTHER PLAN AS DEFINED IN SECTION 1.42(f)*
>
> (a) An Other Plan, as defined in Section 1.42(f), shall have primary responsibility for providing benefits. The above designation of an Other Plan as defined in Section 1.42(f) as primary shall prevail over any state or local law or regulation or provision in such Other Plan inconsistent therewith or contrary thereto.

An "Other Plan," as defined in section 1.42(f) of the Fund plan document, includes any

> Automobile, motorcycle or other motor vehicle insurance coverage authorized by law to provide benefits to or for a Covered Individual for bodily and psychological injury, including but not limited to, related hospital, surgical, dental and other medical expenses, which expenses are also covered by this Plan, and which insurance coverage was issued in conformity with "no-fault" type or "personal injury protection" type laws or other similar state or local laws or regulations.

By these provisions, the Fund deems itself an insurer of last resort responsible for expenses left uncovered by all other insurance policies.

The defendant's position, similarly, is based upon a coordination of benefits clause in the auto insurance contract. That provision states that, under policies denominated as "secondary med/wage," medical expenses are not covered "to the extent similar benefits are paid or payable under any other insurance, service, benefit or reimbursement plan. . . ." Because the Cramptons' policy was designated "secondary med/wage," Indiana Insurance claims that it is the proper insurer of last resort. It asserts, therefore, that it need not pay on Mrs. Crampton's claim unless all other insurance benefits are exhausted.

Legal Discussion

Michigan law requires insurance companies providing personal protection insurance to offer, "at appropriately reduced premium rates," a coordination of benefits clause to persons with other health or accident coverage. Mich. Comp. Laws § 500.3109a. In *Federal Kemper Insurance Co. Inc. v. Health Insurance Administration, Inc.*, 383 N.W.2d 590 (1986), the Michigan Supreme Court interpreted this provision as imposing primary liability upon a health insurer where both the health insurer and the personal protection insurer claimed to be secondary insurers under enforceable coordination of benefits clauses. The Court based its holding on the legislature's purpose in enacting the provision: reducing insurance costs by lessening the cost of no-fault policies in dual coverage situations.

The parties do not dispute that the Michigan statute, and its judicial interpretation, do not dictate the result here. To the extent that the Michigan law imposes benefits level requirements on the Fund, it is preempted. *Fort Halifax Packing Co., Inc. v. P. Daniel Coyne*, 107 S.Ct. 2211, 2218 n.8 (state laws mandating benefits payments "relate" to an employee benefit plan, and thus are preempted, "if they attempt to dictate what benefits shall be paid under a plan"). The question presented, rather, is what effect should the defendant's coordination of bene-

fits clause be given in the absence of the Michigan no-fault law.

The plaintiffs assert that the defendant's insurance contract is encompassed within the scope of ERISA preemption, thereby presumably rendering it unenforceable. They raise three arguments in support of this position. First, they assert, a defendant cannot divorce the contents of its insurance policy from the state law pursuant to which it was adopted. To find otherwise would allow a state to regulate indirectly benefit levels it could not enforce directly. Secondly, the Fund claims that giving effect to an insurance policy like that here would allow a fund beneficiary to unilaterally alter the benefit levels set by the trustees simply by accepting an insurance company's offer of a coordinated benefits clauses. Such results, the plaintiffs claim, undermine the uniformity Congress sought to protect by enactment of the preemption clause. Finally, the plaintiffs point to several court decisions supporting their view.

The court finds these arguments unconvincing. Although ERISA preemption is undisputably broad, it is not omnipresent. By its own terms, the provision only supersedes "any and all *State laws* insofar as they may now or hereafter relate to any employee benefit plan" covered by the Act. 29 USC § 1144(a) (emphasis added). Nor has any higher court, so far as this court is aware, found that ERISA negates private contracts. As one court has explained:

> the preemption problem is irrelevant to the existence of a valid contract because nothing in ERISA indicates that Congress intended to make contracts unenforceable. Rather, if the state law is preempted, then the contract must be construed in accordance with federal law, in this case the federal common law of contract. . . . Preemption would not make the contract a nullity.

Holliday v. Xerox Corp., 555 F.Supp. 51, 55 (E.D. Mich. 1982), *aff'd*, 732 F.2d 548 (6th Cir. 1984), *cert. denied*, 469 U.S. 917 (1984). Because federal common law supplies the rule of decision in this case, the plaintiffs' contention that the state is indirectly exercising authority over the Fund is incorrect. The regulatory authority here is federal law; the insurance contract (as well as the ERISA plan) is the object of regulation.

Similarly without merit is the Fund's claim that, absent preemption of the insurance contract, beneficiaries may unilaterally set their level of benefits. Given the manner in which the Fund has chosen to draft its plan—as a secondary or excess liability provider—that problem exists independent of preempted state law. An ERISA-covered employee's decision to lower (or raise) his personal insurance coverage affects the potential benefits paid out by the Fund; so does a state's decision to mandate that individuals carry a certain level of coverage. Nothing suggests that the employee's decision is barred by ERISA; the state's power to implement such policy choices was explicitly held not preempted by the Supreme Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

The plaintiffs do cite several opinions from Michigan courts, both federal and state, granting summary judgment to ERISA benefit funds for the reasons plaintiffs urge here. None of these cases is binding on the court, and I decline to follow them. Like this court, each of those courts found that ERISA preempted the Michigan legislature's coordination of benefits provision. That ended their analysis, however. They merely assumed that preemption of a law renders unenforceable private actions taken under that law. Because I believe that assumption is incorrect, those decisions are not persuasive to this court.

With these arguments aside, the remaining task here is to determine the primary coverage provider under federal common law. To this end, the defendant urges me to look to Michigan law and, specifically, the Michigan Su-

preme Court's decision in *Federal Kemper*. It points out that both the Fund plan and the Indiana Insurance policy were created and/or executed in Michigan. Although I agree that Michigan is undoubtedly the center of the transactions at issue here, I find the defendant's argument untenable. The Michigan primary coverage rule, as I have already explained, is preempted. To resurrect it in the form of federal common law would be both pointless and contrary to the federal interests federal common law serves to protect.

This does not suggest that the court must sail rudderless through the already murky waters of federal common law. The proper analysis to employ in parsing out competing coordination of benefits clauses is well established under general state law and has been adopted in at least one federal appellate decision involving similar circumstances. *Northeast Dept. ILGWU v. Teamsters Local 229*, 764 F.2d 147, 159 (3d Cir. 1985). I need not consider at length the first step in that analysis—determining the intent of the insurers as to the source of primary coverage. See 16 *Couch on Insurance* § 62.44 at 480 (2nd ed. 1983). Each of the conflicting provisions at issue here plainly provides primary coverage unless another source of benefits is available. Like the court in *Northeast Dept. ILGWU*, which dealt with conflicting secondary insurance clauses in two ERISA plans, I find that discerning from the language of the clauses which party was intended to provide coverage "is simply impossible." 746 F.2d at 161. Given this dilemma, the court believes that the baby here must be cut in two. Thus, I follow the general approach finding such clauses "mutually repugnant" and holding both insurers primarily liable on a pro rata basis. 8A Appleman, *Insurance Law and Practice* & 5909 at 399 (1981); 16 *Couch on Insurance* §§ 62:79-62:81; *Northeast Dept. ILGWU*, 764 F.2d at 161, n.13.

Conclusion

The parties are ordered to prorate liability for Mrs. Crampton's injuries according to the amount of coverage provided by each. Since this result is in accordance with the defendant's alternate request for relief, see Def. Response at 9, the court grants Indiana Insurance's motion for summary judgment. The plaintiffs' motion, accordingly, is denied.

It is so ordered.

/s/ SUSAN GETZENDANNER
Susan Getzendanner
United States District Judge

August 8, 1987

APPENDIX C

No. 87-1201

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

HAWKEYE-SECURITY INSURANCE COMPANY,
Plaintiff-Appellant,

v.

TEAMSTERS CENTRAL STATES HEALTH & WELFARE FUND,
Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of Michigan.

Decided and Filed June 21, 1988

BEFORE: NELSON and BOGGS, Circuit Judges, and EDWARDS, Senior Circuit Judge.

PER CURIAM. In rendering summary judgment for the defendant in this case, the district court held that Mich. Comp. Laws §500.3109(a), a provision of Michigan's No-Fault Automobile Insurance Act, was preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001-1461. We subsequently held that §500.3109(a) has not been so preempted. *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 56 U.S.L.W. 3786 (5/17/88). That decision is dispositive of this appeal. Accordingly, the judgment of the district court is REVERSED, and the case is REMANDED with instructions to enter judgment for the plaintiff. *See Federal Kemper Ins. Co. v. Health Ins. Administration*, 424 Mich. 537, 383 N.W.2d 590, 596 (1986).

APPENDIX D

I.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

29 U.S.C. Section 514

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * *

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

29 U.S.C. Section 3

§ 3 Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. Section 402

§ 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

29 U.S.C. Section 403

§ 1103. Establishment of trust

(a) Benefit plan assets to be held in trust; authority of trustees

Except as provided in subsection (b) of this section, all assets of an employee benefit plan shall be held in trust by one or more trustees. Such trustee or trustees shall

be either named in the trust instrument or in the plan instrument described in section 1102(a) of this title or appointed by a person who is a named fiduciary, and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan, except to the extent that—

(1) the plan expressly provides that the trustee or trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees shall be subject to proper directions of such fiduciary which are made in accordance with the terms of the plan and which are not contrary to this chapter, or

(2) authority to manage, acquire, or dispose of assets of the plan is delegated to one or more investment managers pursuant to section 1102(c)(3) of this title.

29 U.S.C. Section 404

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

* * * * *

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

II.

MICHIGAN NO-FAULT INSURANCE ACT

Mich. Comp. Law Ann. § 500.3109a

500.3109a. Deductibles and exclusions relating to other health and accident coverage

An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

Mich. Comp. Law Ann. § 500.3101

500.3101. Security for payment of benefits under personal and property protection and residual liability insurance; definitions

(1) The owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance, property protection insurance, and residual liability insurance. Security shall only be required to be in effect during the period the motor vehicle is driven or moved upon a highway. Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy on a motor vehicle that is not driven or moved upon a highway may allow the insured owner or registrant of the motor vehicle to delete a portion of the coverages under the policy and maintain the comprehensive coverage portion of the policy in effect.

Mich. Comp. Law Ann. § 500.3107

500.3107. Personal protection insurance benefits, allowable expenses, work loss

Personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation. Allowable expenses within personal protection insurance coverage shall not include charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except when the injured person requires special or intensive care, or charges for funeral and burial expenses in excess of $1,000.00.

III.

MICHIGAN INSURANCE CODE OF 1956

Mich. Comp. Law Ann. § 500.2236

500.2236. Basic insurance policy and annuity contract forms Filing, approval, size of type

(1) No basic insurance policy form or annuity contract form shall be issued or delivered to any person in this state, and no application form where a written application is required and is to be made a part of such policy or contract, no printed rider or indorsement form or form of renewal certificate, and no group certificate in connection with any such policy or contract, shall be issued or delivered to any person in this state, until a copy of the form thereof is filed with the department of insurance and approved by the commissioner as conforming with the requirements of this code and not inconsistent with the law. Failure of the commissioner to act within 30 days after submittal shall constitute approval. All such forms, except policies of disability insurance as defined in section 3400[1] shall be plainly printed with type size not less than 8-point

unless the commissioner determines that such portions of any such form printed with type less than 8-point is not deceptive or misleading.

* * * * *

Application of section

(6) The filing requirements of this section shall not apply to:

(a) Insurance against loss of or damage to:

(i) Imports, exports, or domestic shipments.

(ii) Bridges, tunnels, or other instrumentalities of transportation and communication.

(iii) Aircraft and attached equipment.

(iv) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(b) Insurance against loss resulting from liability, other than worker's compensation or employers' liability arising out of the ownership, maintenance, or use of:

(i) Imports, exports, or domestic shipments.

(ii) Aircraft and attached equipment.

(iii) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder or certificate holder. Beginning September 1, 1986, the commissioner by order may exempt from the filing requirements of this section and sections 2242, 3606, and 4430[4] for so long as he or she deems proper

any insurance document or form or type thereof, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a,[5] as specified in the order to which this section practicably may not be applied, or the filing and approval of which are deemed unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a, exempt by order of the commissioner from the filing requirements of this section and sections 2242 and 3606 are deemed approved by the commissioner for purposes of section 3430.[6]